



Legionellosis

County _____

LHJ Use ID _____

☐ Reported to DOH Date ____/____/____

LHJ Classification ☐ Confirmed

☐ Probable

By: ☐ Lab ☐ Clinical

☐ Epi Link: _____

☐ Outbreak-related

LHJ Cluster# _____

LHJ Cluster
Name: _____

DOH Outbreak # _____

REPORT SOURCE

LHJ notification date ____/____/____

Reporter (check all that apply)

☐ Lab ☐ Hospital ☐ HCP

☐ Public health agency ☐ Other

OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation
start date: ____/____/____

Reporter name _____

Reporter phone _____

Primary HCP name _____

Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____

Address _____ ☐ Homeless

City/State/Zip _____

Phone(s)/Email _____

Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____

Zip code (school or occupation): _____ Phone: _____

Occupation/grade _____

Employer/worksite _____ School/child care name _____

Birth date ____/____/____ Age _____

Gender ☐ F ☐ M ☐ Other ☐ Unk

Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (check all that apply)

☐ Amer Ind/AK Native ☐ Asian

☐ Native HI/other PI ☐ Black/Afr Amer

☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ____/____/____ ☐ Derived

Diagnosis date: ____/____/____

Illness duration: ____ days

Signs and Symptoms

Y N DK NA

☐ ☐ ☐ ☐ **Fever** Highest measured temp (°F): _____
☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk

☐ ☐ ☐ ☐ **Cough** Onset date: ____/____/____

☐ ☐ ☐ ☐ Nonproductive cough

☐ ☐ ☐ ☐ **Muscle aches or pain (myalgia)**

Predisposing Conditions

Y N DK NA

☐ ☐ ☐ ☐ Chronic liver disease

☐ ☐ ☐ ☐ Immunosuppressive therapy or disease

☐ ☐ ☐ ☐ Chronic diabetes

☐ ☐ ☐ ☐ Chronic lung disease

☐ ☐ ☐ ☐ Smokes tobacco

Clinical Findings

Y N DK NA

☐ ☐ ☐ ☐ **Pneumonia**

X-ray result: ☐ P ☐ N ☐ I ☐ O ☐ NT

☐ ☐ ☐ ☐ Pontiac fever

☐ ☐ ☐ ☐ Admitted to intensive care unit

☐ ☐ ☐ ☐ Mechanical ventilation or intubation required
during hospitalization

P = Positive
N = Negative
I = Indeterminate
O = Other
NT = Not Tested

Hospitalization

Y N DK NA

☐ ☐ ☐ ☐ **Hospitalized for this illness**

Hospital name _____

Admit date ____/____/____ Discharge date ____/____/____

Y N DK NA

☐ ☐ ☐ ☐ **Died from illness** Death date ____/____/____

☐ ☐ ☐ ☐ Autopsy Place of death _____

Laboratory

Collection date ____/____/____

Source _____

P = Positive O = Other
N = Negative NT = Not Tested
I = Indeterminate

P N I O NT

☐ ☐ ☐ ☐ ☐ **Legionella culture (from normally sterile site—
lung tissue, pleural fluid, respiratory secretions,
other fluid)** Species: _____

☐ ☐ ☐ ☐ ☐ ***L. pneumophila* serogroup 1 antigen detection
in urine using validated reagents**

☐ ☐ ☐ ☐ ☐ ***L. pneumophila* serogroup 1 specific serum
antibody titer with ≥ 4-fold rise using validated
reagents (acute and convalescent serum pair)**

☐ ☐ ☐ ☐ ☐ Titer to Legionella species/serogroups other than *L.
pneumophila* serogroup 1, ≥ 4-fold rise [*Suspect*]

☐ ☐ ☐ ☐ ☐ *L. pneumophila* antibody titer to multiple species
(pooled antigen) with ≥ 4-fold rise [*Suspect*]

☐ ☐ ☐ ☐ ☐ Legionella antigen or organism detected by DFA,
immunohistochemistry, or other method [*Suspect*]

☐ ☐ ☐ ☐ ☐ Legionella species detected by validated nucleic
acid assay [*Suspect*]

INFECTION TIMELINE

Enter onset date (first sx)
in heavy box. Count
backward to figure
probable exposure period

Days from
onset:

Exposure period

-10 -2

o
n
s
e
t

Calendar dates:

EXPOSURE (Refer to dates above)

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or
outside of usual routine

Out of: ☐ County ☐ State ☐ Country

Dates/Locations: _____

☐ ☐ ☐ ☐ Travel associated: spent at least one night away
from home in the ten days before onset of illness
(includes same country of residence or abroad)

☐ ☐ ☐ ☐ Patient hospitalized >48 hours before illness onset
days before onset: _____

☐ ☐ ☐ ☐ Work or volunteer in health care setting during
exposure period
Facility name: _____

Y N DK NA

☐ ☐ ☐ ☐ Visited health care setting during exposure period

Facility name: _____

Number of visits: _____

Dates of visits: _____

☐ ☐ ☐ ☐ Travel or overnight stay other than residence
Specify where: _____

☐ ☐ ☐ ☐ Aerosolized water (e.g. fountains, spas,
humidifier, hot tub)

☐ ☐ ☐ ☐ Recreational water exposure (e.g. lakes, rivers,
pools, wading pools, fountains)

☐ ☐ ☐ ☐ Soil exposure (e.g. gardening, potting soil,
construction)

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

Exposure details: _____

☐ No risk factors or exposures could be identified

☐ Patient could not be interviewed

PATIENT PROPHYLAXIS/TREATMENT**PUBLIC HEALTH ISSUES**

Y N DK NA

☐ ☐ ☐ ☐ Nosocomial infection suspected

☐ ☐ ☐ ☐ Visited health care setting during exposure period

Facility name: _____

Date(s) of visit(s): _____

PUBLIC HEALTH ACTIONS

☐ Facility notified

NOTES

Investigator _____ Phone/email: _____ Investigation complete date ____/____/____

Local health jurisdiction _____ Record complete date ____/____/____